Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-271
Employees' Manual, Title 8
Medicaid Appendix

May 11, 2007

REMEDIAL SERVICES MANUAL TRANSMITTAL NO. 07-2

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Remedial Services Manual***, Chapter III, *Provider-Specific Policies*, Table of Contents (page 2), revised; pages 57-66, revised; pages 67, 68, and 69, new; and CMS-1500, *Health Insurance Claim Form*, revised.

Summary

This letter transmits a revision for providers of remedial services that includes:

- A revised CMS 1500 claim form sample.
- Revised instructions for the claim form.

Date Effective

May 1, 2007

Material Superseded

Remove the following pages from Chapter III of the ***Remedial Services Manual***, and destroy them:

Page	Date
Table of Contents (page 2)	March 1, 2007
CMS-1500	12/90
57-66	November 1, 2006

Additional Information

The provider manual can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to the Iowa Medicaid Enterprise Provider Services Unit.

Page

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

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CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ . _____ 3. _____ . _____

2. _____ . _____ 4. _____ . _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**REQUIRED** Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED** Enter the Medicaid member's Medicaid number, found on the *Medical Assistance Eligibility Card*. The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	**REQUIRED** Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	**OPTIONAL** Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.
4.	INSURED'S NAME	**OPTIONAL** For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	**OPTIONAL** Enter the address and phone number of the member, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	**REQUIRED, IF KNOWN** Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME, ETC.	**SITUATIONAL** Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
10.	IS PATIENT'S CONDITION RELATED TO	**REQUIRED, IF KNOWN** Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL** No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**REQUIRED** If the Medicaid member has other insurance, check "yes" and enter payment amount in field 29. If "yes," then boxes 9a-9d must be completed. If there is no other insurance, check "no." If you have received a denial of payment from another insurance, check **both** "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record. Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902. **Note:** Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY	**SITUATIONAL** Enter the date of the onset of treatment as month, day, and year. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	**SITUATIONAL** Chiropractors must enter the current x-ray date as month, day, and year. For all others, no entry is required.
16.	DATES PATIENT UNABLE TO WORK...	**OPTIONAL** No entry required.
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	**SITUATIONAL** Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the healthcare provider that directed the patient to your office.
17a.		**SITUATIONAL** through May 22, 2007. **Note:** "1D" qualifier must precede any entry in this field. If the patient is a MediPASS member and the MediPASS provider authorized service, enter the seven-digit MediPASS authorization number. If this claim is for consultation, independent laboratory services, or medical equipment, enter the Iowa Medicaid number of the referring or prescribing provider. If the patient is on lock-in and the lock-in provider authorized service, enter the seven-digit authorization number. On May 23, 2007, 17a will no longer be in use.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
17b.	NPI	**OPTIONAL** through May 22, 2007. Enter the NPI of the referring provider. On May 23, 2007, the use of the NPI will become mandatory under the following conditions: ♦ If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit NPI of the referring provider. ♦ If this claim is for consultation, independent laboratory services, or medical equipment, enter the NPI of the referring or prescribing provider. ♦ If the patient is on lock-in and the lock-in provider authorized service, enter the NPI.
18.	HOSPITALIZATION DATES RELATED TO...	**OPTIONAL** No entry required.
19.	RESERVED FOR LOCAL USE	**OPTIONAL** No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL** No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED** Indicate the applicable ICD-9-CM diagnosis codes in order of importance to a maximum of four diagnoses (1-primary, 2-secondary, 3-tertiary, and 4-quaternary). If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648 670 through 677 V22 V23
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.
23.	PRIOR AUTHORIZATION NUMBER	**SITUATIONAL** If there is a prior authorization, enter the prior authorization number. Obtain the prior authorization number from the prior authorization form.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. A	DATE(S) OF SERVICE	**REQUIRED** Enter the month, day, and year under both the "From" and "To" categories for each procedure, service or supply. If the "From-To" dates span more than one calendar month, enter each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied. **SHADED** Required for provider administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs). No spaces or symbols should be used in reporting this information.
24. B	PLACE OF SERVICE	**REQUIRED** Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 81 Independent laboratory 99 Other unlisted facility

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. C	EMG	**OPTIONAL** No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED** Enter the codes for each of the dates of service. **Do not** list services for which no fees were charged. Enter the procedures, services or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show HCPCS code modifiers with the HCPCS code.
24. E	DIAGNOSIS POINTER	**REQUIRED** Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. **Do not** write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED** Enter the usual and customary charge for each line item. This is defined as the provider's customary charges to the public for the services.
24. G	DAYS OR UNITS	**REQUIRED** Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the **total minutes** of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	**SITUATIONAL** Enter an "F" if the services on this claim line are for family planning. Enter an "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	**SITUATIONAL** through May 22, 2007. In the shaded portion, enter qualifier "1D" if you are entering a legacy number in field 24.J.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. J	RENDERING PROVIDER ID #	**SITUATIONAL** The "rendering provider" is the practitioner who provided, supervised, or ordered the service. This entry identifies the rendering provider when the identifier given in field 33a is that of a group or is not that of the treating provider. **OPTIONAL** through May 22, 2007. In the shaded portion, enter the rendering provider's individual seven-digit Iowa Medicaid provider number when the provider number given in field 33a does not identify the treating provider. **Note:** Qualifier "1D" must precede any entry into this field. **MANDATORY** as of May 23, 2007. In the lower portion, enter the NPI of the provider rendering the service when the NPI given in field 33a does not identify the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL** No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**FOR PROVIDER USE** Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.
27.	ACCEPT ASSIGNMENT	**OPTIONAL** No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED** Enter the total of the line item charges. If more than one claim form is used to bill services performed, total each claim form separately. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**SITUATIONAL** Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	**REQUIRED** Enter the amount of total charges less the amount entered in field 29.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED** Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	**REQUIRED** Enter the name and address associated with the rendering provider. **Note:** The zip code must match the zip code confirmed during NPI verification or during enrollment. To view the zip code provided, return to imeservices.org.
32a.	NPI	**OPTIONAL** Enter the NPI of the facility where services were rendered.
32b.		**REQUIRED** through May 22, 2007. Enter the seven-digit Iowa Medicaid number of the billing provider. If this number identifies a group or an individual provider other than the provider of service, the rendering provider's Iowa Medicaid number must be entered in field 24J for each line.
33.	BILLING PROVIDER INFO AND PHONE #	**REQUIRED** Enter the complete name and address of the billing provider or service provider. The "billing provider" is defined as the provider that is requesting to be paid for the services rendered. **Note:** The zip code must match the zip code confirmed during NPI verification or during enrollment. To view the zip code provided, return to imeservices.org.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
33a.	NPI	**OPTIONAL** through May 22, 2007 **MANDATORY** as of May 23, 2007 Enter the 10-digit NPI of the billing provider. A provider that does not meet the definition of "health care provider" and therefore does not meet the criteria to receive an NPI should enter the ten-digit provider number assigned by IME (begins with "X00"). If this number identifies a group or an individual provider other than the provider of service, the rendering provider's NPI must be entered in field 24J for each line. **Note:** The NPI must match the NPI confirmed during NPI verification or during enrollment. To view the NPI provided, return to imeservices.org.
33b.		**OPTIONAL** through May 22, 2007 **MANDATORY** as of May 23, 2007 Enter the taxonomy code of the billing provider. **Note:** Qualifier "ZZ" must precede entry of taxonomy in this field. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification or during enrollment. To view the taxonomy code provided, return to imeservices.org.

H. REMITTANCE ADVICE

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting. To view a sample of this form on line, click here.

1. Remittance Advice Explanation

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied, and suspended claims.

- **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.

- **Denied** represents all processed claims for which no reimbursement is made.
- **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Remittance Advice Field Descriptions

NUMBER	DESCRIPTION
1.	Billing provider's name as specified on the *Medicaid Provider Enrollment Application*.
2.	*Remittance Advice* number.
3.	Date claim paid.
4.	Billing provider's Medicaid (Title XIX) number.
5.	*Remittance Advice* page number.
6.	Type of claim used to bill Medicaid.
7.	Status of following claims: • **Paid.** Claims for which reimbursement is being made. • **Denied.** Claims for which no reimbursement is being made. • **Suspended.** Claims in process. These claims have not yet been paid or denied.
8.	Member's last and first name.
9.	Member's Medicaid (Title XIX) number.
10.	Transaction control number assigned to each claim by the IME. Please use this number when making claim inquiries.
11.	Total charges submitted by provider.
12.	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
13.	Total amount of Medicaid reimbursement as allowed for this claim.
14.	Total amount of member copayment deducted from this claim.
15.	Medical record number as assigned by provider; 10 characters are printable.

NUMBER	DESCRIPTION
16.	Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for explanation of the EOB code.
17.	Line item number.
18.	The first date of service for the billed procedure.
19.	The procedure code for the rendered service.
20.	The number of units of rendered service.
21.	Charge submitted by provider for line item.
22.	Amount applied to this line item from other resources, i.e., other insurance, spenddown.
23.	Amount of Medicaid reimbursement as allowed for this line item.
24.	Amount of member copayment deducted for this line item.
25.	Treating provider's Medicaid (Title XIX) number.
26.	Allowed charge source code: **B** Billed charge **F** Fee schedule **M** Manually priced **N** Provider charge rate **P** Group therapy **Q** EPSDT total screen over 17 years **R** EPSDT total under 18 years **S** EPSDT partial over 17 years **T** EPSDT partial under 18 years **U** Gynecology fee **V** Obstetrics fee **W** Child fee

NUMBER	DESCRIPTION
27.	Remittance totals (found at the end of the *Remittance Advice*): • Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of paid adjusted claims, amount billed by provider, and amount allowed and reimbursed by Medicaid. • Number of denied original claims and amount billed by provider. • Number of denied adjusted claims and amount billed by provider. • Number of pended claims (in process) and amount billed by provider. • Amount of check.
28.	Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.